Taylor County Moving For A Cure

Treatment Access Grant Application

CONFIDENTIAL

Applications will be available on June 1, 2018 and accepted until all funds have been distributed. We will not accept applications prior to June 1, 2018. All ages are accepted for this grant who meet the requirements.

To apply for this grant, the following requirements must be met:

1) A resident of Taylor County for at least one year (must provide address for verification).
2) Received or currently receiving chemotherapy, radiation and/or other treatment from a state licensed/certified oncology healthcare provider from May 2017 – June 2018.
3) Provide a letter from a licensed/certified oncologist stating you have received or currently receiving treatment from May 2017 –June 2018 **or**
4) If you required surgery but no treatment for your cancer, a letter from a certified/licensed surgeon or physician confirming surgery and cancer diagnosis from May 2017-June 2018.

We will provide a one-time per year stipend of $1,000.00. If you have been awarded a stipend from this fund previously, priority will be given to new applicants first. There are no requirements on how this money must be spent. Our hope is this funding will provide you some financial relief with paying costs toward such items as personal bills, gas for travel to appointments, groceries, and deductibles towards your costs associated with treatment or childcare.
Please make sure that all sections of this application are complete and have original signatures. Applications can be emailed, fax, placed in the mail or brought to the health department. We will not accept the applications until June 1, 2018 and all requirements are met.

Mail: Taylor County Health Department
ATTN: Patty Krug
224 South Second Street Medford, Wi. 54451

Email: patty.krug@co.taylor.wi.us

Fax: 715-748-1417

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Date of Birth: _____(mm/dd/yyyy) Phone number: _____

Address: _____

City, State, Zip: _____

How long have you lived at this address _____Years

If less than a year, previous address: _____

How long did you live at this address: _____Years

ONCOLOGY HEALTH CARE PROVIDER

Physicians Name: _____

Hospital/Clinic: _____

Address: _____

City, State, Zip: _____

(Please check one) Received or Currently Receiving Treatment during May 2017 - June 2018

Radiation _____ Chemotherapy _____

Other (please list type of treatment) _____

Surgeon/Physician Provider if no treatment required for your cancer during May 2017 - June 2018

Physicians Name: _____

Hospital/Clinic: _____

Address: _____

City, State, Zip: _____

Date of surgery/cancer diagnosis_____

How did you hear about this fund? _____

Have you received money from this fund in the past? Yes____ (Year_____) No_____

I certify that the above information is true and complete to the best of my knowledge.

Applicant's Signature: _____Date _____